Testimony of

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on

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Mr. Chairman and members of the committee, thank you for inviting me here today. Let me begin by saying that posttraumatic stress disorder is real and painful condition. Undoubtedly, it will afflict some men and women returning from Iraq. A humane and grateful country must treat them. But how many will be afflicted is difficult to know at this time.

It is generally put forth as an established truth — that roughly one-third of returnees from Vietnam suffered PTSD. This is at best debatable, given that fifteen percent were assigned to combat units. As we try to help the soldiers of Operation Iraqi Freedom meld back into society, it would be a mistake to rely too heavily on the conventional wisdom about Vietnam.

I will first discuss the questions raised by the government-mandated study on war stress among Vietnam veterans. Second, I will put forth some clinical and social principles for responding to the soldiers who are now rotating home.

The National Vietnam Veterans Readjustment Study: The Research Triangle Institute (under contract from the Veterans Affairs Administration) released the study in 1990. It concentrated on post-traumatic stress disorder, a psychiatric condition marked by disabling painful memories, anxiety and phobias after a traumatic event like combat, rape or other extreme threat.

The NVVRS found that 31 percent of soldiers who went to Vietnam, or almost one million troops, succumbed to PTSD after their return. The count climbed to fully half if one included those given the diagnosis of "partial" post-traumatic stress disorder.

On closer inspection, however, these figures are shaky. As I mentioned, only 15 percent of troops in Vietnam were assigned to combat units, so it is odd that 50 percent suffered symptoms of war trauma. True, non-combat jobs like driving trucks put men at risk for deadly ambush, but Army studies on psychiatric casualties during the war found the vast majority of cases referred to field hospitals did not have combat-related stress at all. Rather, most were sent for psychiatric attention because of substance abuse and behavioral problems unrelated to battle.

Moreover, during the years of the most intense fighting in Vietnam, 1968-69, psychiatrists reported that psychiatric casualties numbered between 12 and 15 soldiers per thousand, or a little more than 1 percent. If the 1990 readjustment study is correct, the number afflicted with diagnosable war stress multiplied vastly in the years after the war. Again, it does not add up.

How to explain the postwar explosion in Vietnam cases? The frequently proffered answer is that the start of the disorder can be **delayed** for months or years. This belief, however, has no support in epidemiological studies. And consider the striking absence of delayed

cases in long-range studies like that of people affected by the Oklahoma City bombing. Such studies have found that symptoms almost always develop within days of the traumatic event and, in about two-thirds of sufferers, fade within a year.

It is worth noting that the concept of delayed post-traumatic stress was introduced in the early 1970's by a group of psychiatrists led by Robert Jay Lifton, an outspoken opponent of the war. They decided that many former soldiers suffered what was called post-Vietnam syndrome — marked by "alienation, depression, an inability to concentrate, insomnia, nightmares, restlessness, uprootedness and impatience with almost any job or course of study" — and that this distinguished veterans of Vietnam from those of any other war.

(It took years for a critical mass of scholarship to accumulate showing that Vietnam veterans were comparable to both Vietnam era veterans and non-veterans in terms of employment, income, level of education, divorce rate, suicide, homelessness.[1])

While there were little data to back up the existence of this delayed syndrome, the image of the veteran as a walking time bomb was a boon to the antiwar movement, which used it as proof that military aggression destroys minds and annihilates souls. Yes, some veterans suffered the crippling anxiety of chronic post-traumatic stress disorder. But the broad-brush diagnosis of post-Vietnam syndrome also served political ends.

There are a couple of other reasons to be skeptical. A well-advertised syndrome like PTSD could have provided a **medicalized explanation** for many unhappy, but not necessarily traumatized, veterans who had been trying to make sense of their experience. This seems particularly relevant to NVVRS subjects who seldom sought care or compensation. Such “effort at meaning” is a deeply human – and well-documented phenomenon.

In addition, the NVVRS researchers **did not measure degree of impairment** in the subjects interviewed. Nor were frequency of symptoms recorded. There is an active debate in the psychiatric literature about over-diagnosis (of many conditions, not just PTSD) prompted by the fact that clinicians or epidemiologists do not always take into account the degree of impairment associated with symptoms. After all, it is not uncommon for some people to have symptoms (e.g., nightmares, painful memories) but to function at a very high level and neither they nor those around them consider them sick. Having too low a threshold for diagnosing pathology was not uncommon at the VA where I worked. I saw, for example, a number of a troubled middle-aged veterans who had only minor complaints of nightmares or occasional disturbing thoughts of Vietnam find themselves misdiagnosed with PTSD. The most recent edition of the Diagnostic and Statistical Manual requires presence of impairment or great suffering. It is very possible that the NVVRS had **too low a threshold for diagnosing PTSD**.

Also, the NVVRS relied heavily on self-report. Psychological studies, however, have shown how **fallible memory** can be. For example, people tend to reconstruct the past in terms of the present--they often exaggerate the degree of earlier misfortune if they are

feeling bad, or minimize old troubles if they are feeling good. A 1997 report in the *American Journal of Psychiatry* by West Haven VA psychiatrists Steven Southwick, Dennis Charney and C. Andrew Morgan ("Consistency of memory for combat-related traumatic events in veterans of Operation Desert Storm," volume154: 173-7) examined Desert Storm veterans at one month and two years after their return to the U.S.

In the group, memory for traumatic events changed from first to second assessment for 88 percent of them (70 percent recalled a traumatic event at two years that they did not mention at the first month evaluation; 46 percent mentioned a traumatic event at one month but not at two years). Veterans with the most PTSD symptoms, the authors wrote, "tend to amplify their memory for traumatic events over time" though are probably unaware how those memories had changed. In other words, individuals with more severe symptoms of anxiety and depression remember a traumatic event as being worse when they are asked about it a second time than when asked about it earlier. Those with fewer symptoms, however, tended to recall the event as less harrowing than they had previously described it. This observation —from other studies of car accident victims, witnesses to a school shooting, international peacekeepers—are remarkably consistent.

Thus it is vital that researchers try to **corroborate the battlefield events** that veterans cite as causes of their post-traumatic stress. Researchers on the NVVRS did not even attempt this. "Unless we avail ourselves of the historical archival material to verify self-reported traumatic events, will never know how much memory distortion has infected the data base on post-traumatic stress disorder," cautions psychologist Richard McNally of Harvard University, author of *Remembering Trauma* (Harvard University Press, 2003.)

Some may believe that military personnel files are woefully unreliable. There is by no means consensus on that contention. True, no data source is perfect, but taking into account the information on personnel files is surely better than relying solely on memories that are over ten years old, often decades old. While no perfect document exists, the best estimate could be derived from triangulating various sources of information, memory included. It is simply hard to believe that there were no other independent sources that could verify, at minimum, whether a soldier was within 100 miles of a combat zone.

Records aside, the NVVRS findings remain problematic for the reasons discussed above. Furthermore, a study conducted by the Centers for Disease Control published in 1988 found that only fifteen percent of veterans ever suffered PTSD and that two percent met criteria at the time of the interview. (The Centers for Disease Control Vietnam Experience Study, " Health status of Vietnam veterans: I. Psychosocial characteristics," *Journal of the American Medical Association* 259: 2701-2707)

"As psychiatrists we are urged to learn the lessons of Vietnam, but no one is sure what those lessons are," says psychiatrist and trauma expert Simon Wessely of King's College London. "Do the explanations for allegedly high rates lie in the jungles of Vietnam," Wessely asks, "in America's struggle to come to terms with the war, or with symptoms manufactured to fit a cultural narrative and expectation of what kinds of mental stress

these veterans would experience?"

Relevance to today? Keep in mind that subjects were interviewed for the NVVRS at *least a decade* after return from Vietnam. Its questionable findings notwithstanding, the study bears little on immediately returning veterans because it measured symptoms present in veterans when they were a decade or more, not weeks, away from being overseas.

A study by Jonathan Borus, a research psychiatrist at the Walter Reed Army Research Institute in the early 70's (now at Harvard) may shed some light here. In 1974 Borus reported data comparing the emotional and behavioral readjustment of almost 600 Vietnam veterans, most of them assigned to combat units, and about 200 non-combat counterparts who served elsewhere overseas or in the U.S. Borus found no difference between the two cohorts of veterans (*Archives of General Psychiatry* vol. 30: 554-7). "From a review of public and professional reports," he wrote, "it seems to me that some mental health professionals have …overstepped their data to support their politics." Not only was Borus' sample twice as large as the NVVRS (which had 300 theater vets), most of them were assigned to combat units and his analysis took place months not decade(s) after the war.

But the most informative glimpse at what is happening now come from a report released just two days ago. The VHA Office of Public Health and Environmental Hazards, Report #4, (March 9, 2004) states **that 436 soldiers out of 107,540** separated from active duty in Iraq **have thus far been diagnosed with PTSD**. This is about .4% of veterans who returned. According to adherents of the NVVRS, we can expect to see a seventy-fold increase in PTSD over the next decade? This is an astounding (and unrealistic) amplification.

Lessons:

1. *interpreting psychological states*: Will many men and women may feel dislocated, sad, bitter? Of course. They may have trouble sleeping and be distractible, even hostile. Is this psychopathology? Depending on how dysfunctional the person is and degree of persistence, it could indeed be.

2. *promoting protective factors*: important to enumerate the factors known to protect against post-traumatic stress symptoms and PTSD. These include the benefits of a smooth reintegration of the veteran into family and community, society's appreciation for his sacrifice, minimal economic hardship, engagement in purposeful work and the ability to derive reward, or at least, meaning from the war experience, as horrible as it might have been at times. The Veterans Administration may have a role in fostering some of these factors.

3. *formal vs. informal care*: Many of the returning young men and women will find comfort and support in the embrace of their families, friends, communities, and houses of worship. Those who are too anxious or depressed to function or who have started

drinking or using drugs heavily should get professional help. Informal discussion groups may be an option.

What is crucial is that the help we give vets does not transform acute problems and into chronic ones. The VA itself has doubtless learned some of those lessons from its treatment of Vietnam veterans.

4. *practical treatment focus*: Group or individual treatment should be focused on solving practical problems and rehabilitation and putting traumatic experiences in perspective. It should not entail repeated telling of terrifying or demoralizing stories and encourage the client to assume the identity of the psychologically crippled veteran. Inpatient treatment should be reserved for those who cannot function. Specialized inpatient PTSD units have been problematic; they seemed to facilitate regression rather than readjustment.

5. *beware of the disability trap*: Also, therapists should not be predicting mental disability or pushing veterans quickly toward obtaining service connected disability payments. Not surprising, disability payments provide an economic incentive to maintain dysfunction. A veteran deemed to be fully disabled by post-traumatic stress disorder can collect $2,000 to $3,000 a month, tax free. If work is often the best therapy (it structures one's life, gives a sense of purpose and productivity, provides important social opportunities and a healthy way to get one's mind to stop ruminating about problems), then ongoing disability payments can be the route to further disability and isolation.

Once a patient gets permanent disability payment, motivation to ever hold a job declines, the patient assumes – often incorrectly -- that he can no longer work, and the longer he is unemployed, the more his confidence in his ability for future work erodes and his skills atrophy. He is trapped into remaining "disabled" by the fact that he was once very ill but by no means eternally dysfunctional. (If disability benefits are unequivocally indicated, lump sum payments with or without a financial guardian might make better sense than monthly installments.)

6. *enlightened skepticism is in order*: Some veterans who did enter the VA medical/disability system, as Paul McHugh M.D., former chairman of psychiatry at Johns Hopkins University, observed, settled easily into the status of PTSD vet. The diagnosis "conferred a status preferable to such alternatives as personality disorder, alcoholism, or adjustment disorder." Veterans would have been better served by a skeptical stance on the part of their therapists. Loren Pankratz, a psychologist retired from a Veterans Administration Medical Center in Oregon, has written extensively about patients who distort their history and make false attributions about the cause of their symptoms. During his 25 years as a VA psychologist, Pankratz regularly dug into the military records of World War II and Vietnam veterans who told him about especially daring or improbable exploits. Pankratz was not interested in exposing or embarrassing these men, and because he was usually able to redirect them into proper treatment, he had no need to tell them he knew their stories were dramatically embellished. Gradually, Pankratz realized that many failed to improve because they were being treated for the wrong problem. Checking records helped guide Pankratz to more appropriate therapy.

7. *don't suggest pathological interpretations to fragile people*: People who are feeling fragile can be very susceptible to suggestion. From the World War I on, psychiatrists have warned about the power of morbid expectations on soldiers and advocated that clinicians raise expectations of recovery, not disability, in those with acute psychological problems. We know, for example, that debriefing after a crisis – counselor-led groups in which victims are urged to rehash the vivid and terrifying aspects of an event – can actually impede the resolution of stress symptoms. Many times acute symptoms will be a normal and temporary, and yes, very painful, part of the readjustment phenomenon. Predicting that vast numbers of Iraq vets have a future of dysfunction ahead of them, is demoralizing and risks fulfilling the prophesy.

Some soldiers will return from Iraq and Afghanistan with severe psychological problems, and we must do everything in our power to help them. The vast majority, however, will be able to adjust --and imposing on them the questionable legacy of Vietnam will not do them any service. As the British psychiatrist Simon Wessely has put it: "Generals are justly criticized for fighting the last war, not the present one. Psychiatrists should be aware of the same mistake."

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[1] The Centers for Disease Control Vietnam Experience Study. Post-Service Mortality among Vietnam Veterans. *JAMA* 257(1987) 790-795; The Centers for Disease Control Vietnam Experience Study: Psychosocial Characteristics JAMA 259 (1988):2701-7; D.A. Pollack, Rhodes P., Boyle, C.A., et al., Estimating the Number of Suicides Among Vietnam Veterans. *Am J Psychiatry* 147 (1990):772-6; news release. Bureau of Labor Statistics, U.S. Department of Labor, Washington, D.C. Oct. 21, 1994 (cited in Burkett and Whitley 1998, p. 317)